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IN THE

# SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1974

No. 74-1110

EASTERN KENTUCKY WELFARE RIGHTS ORGANIZATION, et al.,

*Petitioners,*

*v.*

WILLIAM E. SIMON, Secretary of the Treasury, et al.,

*Respondents.*

IN SUPPORT OF THE PETITIONER

## BRIEF AMICUS CURIAE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

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IN SUPPORT OF THE PETITIONER

## BRIEF AMICUS CURIAE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

### INTEREST OF AMICUS CURIAE

The American Public Health Association (APHA) is a national non-governmental organization established in 1872. Its membership of over 50,000 men and women includes physicians, hospital administrators, nurses, and virtually every other type of health worker, as well as increasing numbers of health consumers. The APHA is the largest public health organization in the world.

Although APHA members are involved in a variety of activities in the public health area, they share a concern for the public's welfare—a concern that transcends both economic and professional self-interest. The APHA "does not constitute an 'industry' threatened by programs that place the public good ahead of private or institutional gain." [American Public Health Association Testimony in *Hearings on National Health Insurance Before the House Comm. on Ways and Means,* 93d Cong., 2d Sess., Vol. 5, at 2069 (1974)]. Its concern is with the development of health care to meet the needs of all members of the public.

Over the past several years, the APHA has noted that many private, non profit hospitals[1] in the United States have failed to live up to their ethical and legal obligations to make available free and below-cost care to persons unable to pay established rates. Through resolutions and other organizational activities, the APHA has consistently opposed governmental and private efforts to limit access of certain sectors of the community to free or below-cost care and has called for an expansion of care available to low-income and disadvantaged people, and, in particular, has called on nonprofit hospitals to provide a reasonable volume of services to those unable to pay.

The APHA believes that Revenue Ruling 69-545 restricts the access of the poor to needed hospital services. It is, accordingly, contrary to established federal policy regarding hospital care [enunciated in *e.g.*, 42 U.S.C. §291c(e)] and is contrary as well to the principles to which the Association has steadfastly adhered over the

[1]For purposes of this brief the terms private nonprofit hospitals, community hospitals, voluntary hospitals, nongovernmental not-for-profit hospitals, or any combination thereof are used interchangeably.



years. As a result of this ruling, hundreds of thousands of low-income persons, including many of the newly unemployed, will be unable to make use of hospital facilities which had once been available to them. The APHA is deeply disturbed that the IRS apparently brought about this major change in its policies on the basis of erroneous assumptions of fact and without affording health professionals and consumers the opportunity to provide information and comment.

Because of its long history of dedication to and involvement in protecting the public welfare, its lack of any direct financial interest in the outcome of the case and the expertise it has developed in matters concerning hospital administration, the APHA believes that it is in a position to offer important information concerning the issues raised in this case. Amicus believes that had it had the opportunity to present this information to the IRS, the Revenue Ruling which is the subject of this action would never have been enacted. Having obtained the written consent of both parties pursuant to Supreme Court Rule 42 (2), the APHA submits this brief in support of Eastern Kentucky Welfare Rights Organization, *et. al.*, petitioners in 74-1110.

## SUMMARY OF THE ARGUMENT

Millions of Americans today lack hospital coverage and are dependent on private, nonprofit hospitals for free and below-cost care. These hospitals were built with the support of private philanthropy and public funds on the understanding that such care would be available to persons unable to pay. For a period of more than 50 years prior to the issuance of Revenue Ruling 69-545, the Internal Revenue Service had been requiring hospitals to provide services to persons unable to pay as a condition

of tax-exempt status under §501(c)(3) of the Internal Revenue Code. This requirement had also been enforced by judicial decisions for a period of 30 years.

The Internal Revenue Service had no authority to eliminate this requirement through a revenue ruling. In so doing, it has undermined the premise on which the private, nonprofit system of hospitals was established, has jeopardized the health of millions of Americans, and has increased the burden on government by giving express approval to and legitimizing the practice of sending non-paying patients to government hospitals.

There has been no change in circumstances sufficient to justify this dramatic shift in federal health policy. Since the cost of hospital care continues to increase, some form of insurance coverage has become essential for most American families in order to pay the cost of hospital care. In 1973, approximately one-tenth of the entire population of the United States was entirely without any such hospital coverage and millions more are inadequately protected. The number of persons without hospital coverage is increasing due to the high unemployment rate. There is no federal legislation on the horizon likely to remedy this gap in hospital coverage.

The Court of Appeals asserted that persons without hospital coverage increasingly have access to hospital services operated directly by governmental bodies. Unfortunately, the trend actually is in the opposite direction. Local government has not been able to keep pace with the increasing costs of hospital care. In some locations, there never have been government hospitals for persons unable to pay. In other locations, such as California, many of these facilities are being phased out, and in some instances, persons just above the Medicaid eligibility



requirements are being turned away from even these governmental facilities.

The current financial position of nonprofit hospitals does not present a barrier to the provision of free and below-cost service. The Medicaid and Medicare programs have improved the financial position of such hospitals, thereby adding to their capacity to provide such services. Furthermore, the free and below-cost service requirement has never required these hospitals to provide such services beyond the extent of their financial ability.

In determining the Medicaid and Medicare reimbursement formulas, Congress determined that hospitals themselves should bear the cost of charity care for other patients. Congress took into consideration the impact Medicaid and Medicare would have in reducing the amount of bad debt and charity service losses incurred by hospitals.

Medicaid and Medicare patients, for whose care the hospitals are fully reimbursed, are not persons unable to pay and cannot be included in fulfillment of the obligation of tax-exempt hospitals to provide charity care.

The requirement that hospitals have an emergency room open to all persons is also not a satisfactory solution to their obligation to persons unable to pay. "Emergency room care" is an ambiguous term which does not set forth any clear obligation of tax-exempt hospitals to persons unable to pay. Moreover, however defined, emergency room care does not meet the needs of the poor for free and below-cost inpatient as well as outpatient hospital services. Such services are not available in, nor appropriate to, the emergency room. The Court of Appeals seemed to imply that the emergency

room should be used as an outpatient clinic. While this use has occurred in the past, it interferes with access of persons with real emergencies to emergency care, and the present trend is to provide outpatient services elsewhere in the hospital or in the community.

Finally, the complete turnabout in the IRS's position on the duty of private, nonprofit hospitals to provide services for persons unable to pay, if proper at all, is a major change in policy that cannot properly be effectuated except through compliance with the Administrative Procedure Act, 5 U.S.C. §551 *et seq.*

## ARGUMENT

### I.

### PRIVATE, NONPROFIT HOSPITALS MUST PROVIDE MEDICAL SERVICES TO PERSONS UNABLE TO PAY, AS THEY HAVE IN THE PAST, IN ORDER TO QUALIFY AS "CHARITABLE" ORGANIZATIONS UNDER §501(c)(3) OF THE INTERNAL REVENUE CODE

Our system of private, nonprofit hospitals was built with the support of private philanthropy and public funds on the premise, understood by all, that these hospitals would make available free and below-cost service for persons unable to pay.[2] The Internal Revenue

[2]The principle on which voluntary hospitals were founded was that financial barriers would not be permitted to deprive a person of necessary service: "Without discussing underlying principles of justice or social administration, we may lay down the principle, generally accepted in this country, that the charges for hospital service should be such as to deprive no one of necessary service. It is in accordance with this principle that municipalities appropriate money for the support of hospitals, and it is this belief that induces philanthropic individuals voluntarily to contribute generous sums toward the erection and maintenance of hospitals. Funds so given

[footnote continued]



Service at an early date recognized the obligation of private, nonprofit hospitals to provide free services to persons unable to pay and uniformly applied this requirement over a period of 50 years. Judicial interpretation of "charitable" under §501(c)(3) of the Internal Revenue Code has held for the last 30 years that such hospitals must provide services to persons unable to pay. The system of private, nonprofit hospitals in the United States has developed to the point where millions of Americans without public or private hospital coverage are dependent on these facilities for free or below-cost care.

Revenue Ruling 69-545, ignoring established case law and the historical development of our health care system, redefined "charitable" as it applies to hospitals to require services to all persons *except* persons unable to pay. This dramatic reversal of federal tax policy not only threatens to destroy the access of millions of Americans to hospital care, but also significantly increases the burdens on government. When private, nonprofit hospitals refuse to provide hospital care to persons unable to pay, there is no place else but government on which the burden of providing such services can fall.

The tradition of private, nonprofit hospitals providing services to indigent persons has its historical roots in the Pennsylvania Hospital, incorporated in 1751 with the support of Benjamin Franklin.[3] On petition of sundry

may properly be used for rich and poor alike; they may with justice be used and consumed by the poor, but if used by the rich, must be used without depleting the funds." S. S. GOLDWATER, ON HOSPITALS 65 (1947).

[3]BENJAMIN FRANKLIN, SOME ACCOUNT OF THE PENNSYLVANIA HOSPITAL 4 (1754) (Reprinted by Institute of the History of Medicine, 1954). The Treasurer of Pennsylvania was

[footnote continued]

inhabitants of the Province of Pennsylvania who represented that individuals would contribute to the support of such a hospital, the House of Representatives passed an Act setting up a special corporation under the name, "Contributors to the Pennsylvania Hospital."[4] Upon raising a sufficient amount of private contributions, the Pennsylvania Hospital received matching funds from the public treasury. The facility was intended to provide medical care in the modern sense of that term. A high quality of hospital care was insured by the decision to take paying patients, who would demand minimum standards of care, as well as taking indigent patients. The conditions in a private, nonprofit hospital such as this were in marked contrast to those in early governmental hospitals, which acquired the reputation of being "pesthouses" where persons came to die. Benjamin Franklin summarized his aspirations for such a hospital as follows:

> In short, a Beggar, in a well regulated Hospital, stands an equal Chance with a Prince in his Palace for a comfortable Subsistence, and an expeditious and effectual Cure of his Diseases.[5]

In keeping with the heritage of the Pennsylvania Hospital, private, nonprofit hospitals in the United States

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authorized to provide two thousand pounds "to be applied to the Founding, Building, and Furnishing" of the hospital after private individuals raised capital stock worth two thousand pounds. *Id* at 11. The hospital was conceived as a facility for short-term medical care. *Id.* at 4. Paying patients were to be admitted. *Id.* at 26. The first year, 24 paying patients and 40 charity patients were admitted, and this pattern of admission was followed thereafter. See E.H.L. CORWIN, THE AMERICAN HOSPITAL 61 (1946).

[4]FRANKLIN, *supra*, note 3, at 4, 5.

[5]BENJAMIN FRANKLIN, SOME ACCOUNT OF THE PENNSYLVANIA HOSPITAL 22 (1754) (Reprinted by Institute of the History of Medicine, 1954).



were able to attract joint funding from public and private sources by continuing to provide care to indigent persons that was usually superior in quality to that provided by many government-operated facilities. The tradition of private, nonprofit hospitals in the United States providing charity care was recognized by the Internal Revenue Service and was the basis on which such hospitals were classified as "charitable" institutions and became eligible to receive tax-exempt contributions from private individuals.

Treasury regulations expressly required hospitals, in addition to the general information required of all applicants for tax-exempt status, to establish by affidavit "whether nonpaying patients are accepted." *See* Regulations 69, §231, Article 511(4) (1926). The reporting requirement was modified by Regulations 101, Art. 101-1(5)[1938] to require hospitals to establish "whether part-pay or non-pay patients are accepted and whether the amounts paid by part-pay patients are more than nominal."[6] These reporting requirements made clear that a hospital entitled to tax-exempt status would have to provide services to persons unable to pay, although this was suggested in the definition of "charitable" as "relief of the poor" in I.T. 1800, II-2 Cum. Bull. 152 (1923).

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[6]Revenue Act of 1938, Ch. 289, 52 Stat. 447. The IRS had stressed the importance of the reporting requirement and stated that in order to determine the tax-exempt status of an organization seeking exemption, it was essential that this information be furnished. MIM. 3537, CUM. BULL. 81 (1927). Subsequent to the Revenue Act of 1938, printed forms were used to gather this kind of information.

While local government often reimbursed private, nonprofit hospitals for the expense of caring for "public charges," the cost of providing care for the medically indigent has been the responsibility of the hospital itself, which absorbed the cost of this care as part of its obligation to provide free and below-cost services to persons unable to pay. Public charges or welfare recipients were persons who were not self-supporting and received assistance for the basic necessities of life from government. Medically indigent persons are persons who can afford their own food, clothing and shelter, but are unable to afford their medical expenses.[7]

The readiness of private nonprofit hospitals to admit many persons unable to pay was a major factor not only in attracting philanthropic contributions, but also in the decision frequently made by a county or municipal government to utilize the facilities for "public charges" instead of building a separate county or municipal hospital.[8] Private, nonprofit hospitals in turn benefited from reimbursement for "public charges" which helped to keep them financially solvent, as they were never able to sustain operations solely from private philanthropy.[9] It has been estimated that in providing hospital care for "public charges" and for persons who were provided hospital services on a free or below-cost basis, the voluntary hospitals were providing on a nation-wide basis 70 percent of all hospital care that indigents received.[10] Mutual advantages for both voluntary hospitals and state

[7]S. HARRIS, THE ECONOMICS OF HEALTH CARE: FINANCE AND DELIVERY 418 (1975).

[8]E.H.L. CORWIN, THE AMERICAN HOSPITAL 68 (1946).

[9]*Id.* at 58, 194.

[10]*Id.* at 195.



and local government resulted from these arrangements.[11]

A major benefit to local government in supporting private, nonprofit hospitals through reimbursement for "public charges" or other forms of assistance was that the medically indigent received free or below-cost care at no expense to the public treasury. For instance, New York was among the few municipalities that provided coverage for some but not all medically indigent persons who could meet eligibility criteria. A study which traced governmental assistance to private, nonprofit hospitals in New York back to colonial times found that the private, nonprofit hospitals treated many medically indigent persons without expectation of reimbursement from any source. For every seven medically indigent patients treated by the private, nonprofit hospitals, the City reimbursed the hospital for the care of three of the patients, while the hospital absorbed the expense of providing care for the remaining four persons.[12]

Many communities, especially in rural areas, were urged to and did rely on private, nonprofit hospitals to provide care for indigent persons instead of constructing public facilities. The Commission on Hospital Care, organized under the auspices of the American Hospital Association, after an extensive analysis of the hospital situation, made just such a recommendation.[13] The Commission urged that small communities should not build both a public and a private hospital for the reason

[11]*Id.* at 194-195.

[12]H. KLARMAN, HOSPITAL CARE IN NEW YORK CITY 410 (1963).

[13]COMMISSION ON HOSPITAL CARE, HOSPITAL CARE IN THE UNITED STATES 17-18 (1947).

that such duplication of facilities or services should be avoided in order to assure that one hospital could be built that would reach optimal size.[14] The Commission recommended against building or expanding a government facility in areas which already had a private, nonprofit hospital.[15] In communities without governmental facilities, the local private, nonprofit hospital became the hospital of last resort for persons unable to pay for hospital care.

Judicial construction of the free and below-cost service obligation of private, nonprofit hospitals developed on a case by case basis, which provided different courts the opportunity to observe the role of these hospitals in a variety of different communities and at different times in the development of our system of private, nonprofit hospitals. These cases are rich in detail concerning the various aspects of the problem of providing hospital care for urban, as compared to rural communities, and in areas with many hospitals, as compared to locations that are served by only a few hospitals. *See* the cases cited by the Court of Appeals, 506 F.2d 1278, 1287. Despite the scrutiny of a large number of different factual circumstances, virtually every judicial consideration of the construction of "charitable" as it applies to hospitals agreed that private, nonprofit hospitals are required to provide services to persons unable to pay. Revenue Ruling 56-185 summarized the collective wisdom of these cases, and correctly concluded that "charitable" status is reserved for hospitals which provide free and below-cost services to persons unable to pay. In reversing this requirement by issuing Revenue Ruling 69-545, without

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[14] *Id.* at 68.

[15] *Id.* at 67.



opportunity for public debate or comment, the IRS went beyond its lawful authority.

Revenue Ruling 69-545 adds to, rather than lessens, the burdens of government by specifically encouraging private, nonprofit hospitals to "dump" their charity patients on the local public hospitals. This practice has been recognized to be harmful both to government hospitals and to the poor.[16] The "dumping" policy is expressed in Revenue Ruling 69-545 as follows:

> The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. . . . Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

Disposal of unwanted indigent patients by private, nonprofit hospitals is precisely the type of activity that was disapproved in *Sonora Community Hospital*, 46 T.C. 519, 524 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968) and was a factor in the denial of tax-exempt status to that hospital:

> Its practice was to refer charity patients to the County Hospital, and on occasion when a charity patient was admitted in an emergency it would have him transferred when circumstances permitted to the County Hospital.

As the 1959 regulation [Treasury Regulation, §1.501(c)(3)-1(d)(2)] defining "charitable" recognizes, organizations are granted tax-exempt status to relieve

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[16] See Roemer & Mera, *Patient Dumping and Other Voluntary Agency Contributions to Public Agency Problems,*" 11 MED. CARE 30 (Jan.-Feb. 1973). Woodward, *Poor Hurt by Transfers, Doctor Says*, Washington Post, Sept. 30, 1971, at 17, col. 1.

government of some of its burdens and not to increase them.

Our system of hospital care has relied on private, nonprofit hospitals to absorb the cost of providing services to persons unable to pay. If they fail to fulfill this obligation, many persons may for the first time be without access to hospital care of any kind. After 50 years of private philanthropy and public funds being invested in these facilities, to the exclusion of alternative modes of financing hospital care, a reversal in the meaning of "charitable" as applied to hospitals cannot be justified under any circumstances that presently exist.

## II.

## THE ISSUANCE OF REVENUE RULING 69-545 CANNOT BE JUSTIFIED BY A CHANGE IN CIRCUMSTANCES.

In sustaining Revenue Ruling 69-545, the Court of Appeals sanctioned a fundamental shift in federal health policy: elimination of the requirement that hospitals qualifying for §501(c)(3) status accept patients in need of hospital care who are unable to pay for all or part of the cost of such services. In so ruling, the Court below appears to have given great weight to what it perceived to be "changing economic, social and technological precepts and values of contemporary society," 506 F.2d 1278, 1288. In particular, the Court made a number of assumptions—unsupported by the record—concerning the financing and delivery of health care to the poor.[17]

[17]The Court reasoned as follows: "In the field of health care, the changes have been dramatic. Hospitals in the early part of this nation's history were almshouses supported by philanthropy and serving almost exclusively the sick poor. Today, hospitals are the primary community health facility for both rich and poor. Philan-

[footnote continued]



Amicus respectfully submits that these assumptions have no basis in fact and reflect an erroneous view of the circumstances in which millions of low-income persons find themselves today.

It is true that health care financing and delivery have undergone changes during the past few decades. The costs of hospital services have risen precipitously, and the number of persons with public or private hospital insurance coverage for such expenses has increased markedly. However, these developments have not significantly altered the dependence of millions of poor, working poor, and other persons without hospital coverage upon free or below-cost hospital services. These families and individuals simply cannot afford the high cost of hospital care. In many areas, no public hospital alternative exists. And where such facilities do operate, years of underfinancing and neglect have frequently resulted in inadequate staffing, overcrowding, and substantial deterioration of the physical plant and equipment. At the same

throphy accounts for only a minute percentage of the hospital's total operating costs. Those costs have soared in recent years as modernization of equipment and facilities is necessitated by the advances in medical science and technology. *The institution of Medicare and Medicaid in the last decade, combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below-cost hospital services.* Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. *Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay.* Thus, it appears that the rationale upon which the limited definition of "charitable" was predicated has largely disappeared. To continue to base the "charitable" status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of health care." *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278, 1288-89 (D.C.Cir. 1974) (footnotes omitted, emphasis added).

time, many private nonprofit hospitals have enhanced their financial positions considerably. In sum, neither the need for free and below-cost services, nor the capacity of private, nonprofit hospitals to deliver such care, has by any means disappeared.

**A. Millions of Americans Remain Wholly Dependent Upon Private, Nonprofit Hospitals for Free and Below-Cost Services.**

It is true, as the Court below suggests, that Medicaid, 42 U.S.C. §1396 *et seq.* and to a lesser extent Medicare, 42 U.S.C. §1395 *et seq.*, have made hospital coverage available to many low-income persons who would otherwise be without protection.[18] What the Court overlooked, and what this case concerns, is that portion of the populace which "falls into the cracks" between Medicare, Medicaid, and private health insurance coverage. Because the overlap between public and private coverage is not known,[19] the number of persons without economic protection against the costs of hospitalization can only be estimated. Amicus submits that in 1973, prior to the current rise in unemployment figures, the number of persons so situated fell in the neighborhood of 20 to 25 million—roughly one-tenth of the population.[20] Revenue Ruling 69-545 has left this class of families and individuals totally exposed to the "astronomical costs of hospitalization which bear so heavily on the resources of most Americans," *Memorial Hospital v. Maricopa County*, 415 U.S. 250, 265 (1974).



In order to appreciate fully the devastating impact of Revenue Ruling 69-545 on millions of poor and working poor, a basic understanding of major trends in the cost and financing of hospital services is necessary. First, the price of hospital services has risen dramatically over the past two and one half decades, and continues to do so. In fiscal year 1950, the total expense per patient day in private, nonprofit hospitals was $15.62; by fiscal year 1972, this figure had increased more than 600 percent to $105.21.[21] This inflationary pattern shows no sign of abating. During the first eleven months following the expiration of price controls on the health care industry,[22] hospital service charges rose 15.4 percent; hospital

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[18]Since the advent of Medicaid, utilization of physician services by the poor has increased markedly. See B. BLECHMAN, E. GRAMLICH & R. HARTMAN, SETTING NATIONAL PRIORITIES: THE 1975 BUDGET 210-11 (1974).

[19]Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience*, 38 SOCIAL SECURITY BULL. 21, 22 (Feb. 1975).

[20]According to the Office of Research and Statistics of the Social Security Administration, some 41 million Americans under age 65 had no private health insurance protection against the expense of hospitalization in 1973. *Id.* at 21. An estimated 17.4 million of these (20.9 million total Medicaid beneficiaries less 3.5 million aged 65 and over) were covered by Medicaid. *Id.* at 22. Thus, roughly 23.6 million Americans under 65 had no private health insurance or Medicaid coverage. Some of these, in turn, had hospital coverage under programs such as workmen's compensation and the civilian health care program for the armed services (CHAMPUS), but these numbers were not large. Given the approximate nature of these aggregate statistics, it seems reasonable to conclude that somewhere between 20 to 25 million persons had no protection against hospital costs in 1973.

[footnote continued]

[21]Davis, "Lessons of Medicare and Medicaid for National Health Insurance," in *Hearings on National Health Insurance and Health Care Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 93d Cong., 1st & 2d Sess., 93-69, ser. at 210 (1974).

[22]Under the Economic Stabilization Program, implemented under the authority contained in the Economic Stabilization Act

[footnote continued]

semi-private room rates climbed 19.1 percent.[23] During this same period, the increase in the consumer price index for all goods and services was considerably lower—9.0 percent.[24] Between 1966 and 1974, the cost per patient day in nonprofit hospitals, adjusted to account for the volume of outpatient visits, climbed from $43.58 to $110.77.[25] There is no sound reason to believe that this inflationary trend will change substantially in the foreseeable future.[26]

As the price of hospital services has increased, the importance of third-party payments for such services has grown. Of the total amount of personal hospital expenditures in fiscal year 1950, some 34 percent was paid out of pocket by consumers directly to hospitals; payments to hospitals by third parties, principally public and private

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of 1970, Pub. L. No. 91-379, Title II, 84 Stat. 799, hospital service prices were controlled from the period August 1971 through April 1974.

[23]The period to which these figures apply is May 1974, through April 1975. U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, MONTHLY LABOR REVIEW 102 (1975).

[24]*Id.* at 97.

[25]Worthington, *National Health Expenditures,* 1929-74, 38 SOCIAL SECURITY BULL. 3, 4 (Feb. 1975).

[26]It is widely recognized by independent analysts that, absent reinstatement of price controls on the health industry or major structural changes in the delivery and financing of health care, the costs of hospital and medical services cannot be effectively contained. See, e.g., Robbins, *Health Costs—A One-Way Street,* Wall Street Journal, May 8, 1975, at 10, col. 3; Statement of InterStudy in *Hearings on National Health Insurance Before the House Comm. on Ways and Means,* 93d Cong., 2d Sess., Vol. 3, at 1289-1324 (1974); V. FUCHS, WHO SHALL LIVE? 94-104, 149-151 (1974). Neither price controls nor major structural changes seem imminent.



insurance, accounted for the remaining 66 percent.[27] By fiscal year 1972, direct consumer payments accounted for only 8 percent of all personal hospital expenditures at community hospitals; the remaining 92 percent of such payments came from third parties.[28] Thus, while more and more families and individuals have obtained third-party coverage to protect themselves against the continuously escalating price of hospital services, those without such coverage find themselves exposed to ever-increasing financial risk.

Third-party payors, in turn, fall into two broad categories: public and private. The two principal public programs which provide hospital services financing to eligible beneficiaries are Medicare and Medicaid. Medicare is a program of health insurance for aged and disabled Social Security beneficiaries financed and administered by the federal government.[29] As of July 1, 1973, some 21.5 million persons aged 65 and over, as well as 1.7 million disabled, were eligible for hospital insurance benefits under Part A of Medicare.[30] Medicaid is the state-administered program of medical assistance for low-income persons who are recipients of either Aid to Families with Dependent Children (AFDC), 42 U.S.C. §601 *et seq.*, or the Supplemental Security Income

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[27]*Hearings on National Health Insurance and Health Care, supra,* note 21, at 210.

[28]*Id.*

[29]For a brief description of the Medicare program, see STAFF OF HOUSE COMM. ON WAYS AND MEANS, 93 Cong., 2d Sess., NATIONAL HEALTH INSURANCE RESOURCE BOOK 429-33 (1974).

[30]Ruther, *Medicare, Number of Persons Insured, July 1, 1973,* 38 SOCIAL SECURITY BULL. 33 (June, 1975).

Program for the aged, blind, or disabled (SSI), 42 U.S.C. §1381 *et seq.*[31] All states electing to participate in Medicaid must share with the federal government the cost of certain medical services, including hospital care. 42 U.S.C. §1396d(a)(1). In 1973, some 23.5 million persons were eligible for medical assistance; it is estimated that this figure will increase to 28.6 million in 1975.[32]

The major private third-party payors for hospital services are the commercial indemnity insurers and the non-profit service benefit plans.[33] As of December 31, 1973, prior to the current recession, an estimated 146 million persons under age 65 had some form of hospital coverage under private health insurance plans,[34] primarily in the form of group health insurance policies offered unilaterally or jointly by employers or employees. As of April, 1972, an estimated 46 million full-time workers—some 70 percent of the full-time civilian labor force—had employment-related group health insurance coverage.[35]

Notwithstanding the implementation of Medicaid and Medicare and the expansion of private health insurance

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[31]For a brief description of the Medicaid program, see NATIONAL HEALTH INSURANCE RESOURCE BOOK, *supra*, note 29, at 487-90.

[32]*Id.* at 491.

[33]For a brief discussion of private health insurers, see J. KRIZAY & A. WILSON, THE PATIENT AS CONSUMER (1974).

[34]Mueller, *supra* note 19, at 24. This is the estimate of the Social Security Administration's highly regarded Office of Research and Statistics as to the net number of different persons covered; the estimates of the Health Insurance Association of America are substantially higher.

[35]Kolodrubetz, *Group Health Insurance Coverage of Full-Time Employees*, 1972, 37 SOCIAL SECURITY BULL. 17 (April 1974).



enrollment, millions of Americans lack any third-party coverage whatsoever for the often crushing expense of hospitalization. Due to restrictive eligibility standards adopted by a number of states,[36] Medicaid fails to reach many low-income individuals and families. In 1974, an estimated 9 million poor people were excluded from medical assistance.[37] Similarly, many of the poor and working poor have been passed over by the growth in private hospital insurance coverage. In 1970, some 47 percent of those persons earning between $3,000 and $5,000 per year had no private hospital insurance coverage at all; of those earning between $5,000 and $10,000 per year, approximately 20 percent had no private hospital insurance.[38] As a result, roughly one out of every ten Americans has no hospital coverage whatsoever.[39] And many of those covered find themselves inadequately protected against the financial burdens associated with hospitalization.[40]

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[36]See, e.g., Butler & Schneider, "Analysis of Title II of S.2513 (Long-Ribicoff)—Proposal for National Health Insurance," in *Hearings on National Health Insurance Before the House Comm. on Ways and Means*, 93d Cong., 2d Sess., Vol. 7, at 3116-18 (1974).

[37]Mueller, *supra* note 19, at 22.

[38]Statement of Perrin in *Hearings on National Health Insurance and Health Care Before the Subcomm. on Public Health and Environment of the Comm. on Interstate and Foreign Commerce*, 93d Cong., 1st & 2d Sess., Ser. 93-69, at 342, Table 2 (1974).

[39]*Supra* note 20.

[40]As the costs of hospital care have climbed in recent years, the protection afforded by private health insurance has declined. In 1971, private health insurance met 82 percent of consumer expenditures for hospital care; by 1973, the proportion of hospital expenditures met by health insurance had dropped to 75 percent. Mueller, *supra* note 19, at 37. Thus, those persons with private

[footnote continued]

Obviously the class of persons dependent upon private, nonprofit hospitals for free and below-cost services is large even when employment is high. When economic conditions deteriorate, however, this class can expand rapidly, as our current dilemma illustrates. Between December 1973 and March 1975, the official unemployment rate rose from 4.7 percent to 8.7 percent.[41] Because most private health insurance coverage is employment-related, loss of one's job is usually followed by loss of one's health insurance.[42] Thus, as of March 1975, some 7.5 million workers were unemployed. About 6 million of these, and some 9.4 million of their dependents, were receiving unemployment compensation at that time; however, of these 15.4 million persons, nearly 10

health insurance coverage of some kind must meet, on average, one fourth of their rising hospital bills out of pocket, usually in the form of deductibles and/or coinsurance. Moreover, the extent to which private health insurance policies protect the insured against financial hardship of hospitalization expenses varies enormously. Those with individual health insurance policies usually have less complete coverage purchased at greater expense than those enrolled under employment-related group policies. KRIZAY & WILSON, *supra* note 33, at 5. And workers in low-wage industries tend to have group health insurance coverage (when they have it at all) that is far less comprehensive than that enjoyed by employees in higher-wage industries. *Id.* at 32-33. A low-income worker with limited hospital coverage may therefore find himself in need of free or below cost services if a serious illness in his family requires extended hospitalization, exhausting his insurance benefits before the need for hospital services has ended.

[41]H.R. REP. NO. 171, Emergency Health Insurance Extension Act of 1975, 94th Cong., 1st Sess. 20 (1975).

[42]Most employer-related health insurance coverage terminates when the worker is laid off; under nearly three-fourths of such policies, benefits are discontinued within the 30-day period following layoff. *Id.* at 24-25.



million had no health insurance coverage.[43] The remaining 1.5 million unemployed workers, and an unknown number of their dependents, were not receiving any unemployment compensation and, in all likelihood, had lost their health insurance coverage.[44] Unable to afford private insurance,[45] and ineligible for Medicare or Medicaid,[46] more than ten million recently unemployed

[43]*Id.* at 30.

[44]Those individuals and families who have lost their source of income due to unemployment and in addition are unable to offset this loss even partially through unemployment compensation will rarely be in a position to continue payment of their private health insurance premiums—assuming, of course, that they were covered while employed.

[45]Nearly all employment-related health insurance policies contain "conversion options" which enable a worker who has lost his job (and therefore his membership in the insured group) to obtain coverage on an individual basis. However, the premium for individual coverage is usually 30 to 50 percent higher than that for the group policy, and the scope of coverage is usually much more limited. The higher premium levels associated with conversion usually preclude unemployed workers, with only limited financial resources, from exercising this option. Thus, most lose their coverage within a month after layoff. *Id.* at 26.

[46]In a recent report on emergency health insurance legislation, the House Committee on Interstate and Foreign Commerce explored the limited public alternatives available to the recently unemployed: "Not only do the unemployed generally lose their employment-based health insurance, they are not usually able to obtain alternative coverage under public programs. Half the States preclude male-headed families from receiving Medicaid. In those states which cover male-headed families, Federal law prohibits unemployment compensation recipients from receiving AFDC payments and, by cross-reference, Medicaid. Thus, while dependent children under 21 might be able to obtain coverage in some States, most unemployment compensation recipients cannot qualify for

[footnote continued]

workers and their families have joined the 20 or so million who are totally exposed to the financial hardship associated with hospitalization.

Clearly, circumstances have not improved significantly for these citizens. Nor are they likely to change in the near future. Realistically viewed, the prospects for remedial legislative intervention are dim. Congress recently gave serious consideration to various measures designed to alleviate the plight of the millions of recently unemployed and their dependents who are without health insurance coverage.[47] Despite strong support from organized labor and numerous health interest groups, legislative proposals addressed to this problem have languished in the face of jurisdictional disputes and concern over costs.[48] And even if some form of health insurance coverage for the recently unemployed is by some chance enacted in the near future, it is unlikely to solve the difficulties faced by large numbers of the poor

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Medicaid. Medicare covers only the aged and disabled (with a two-year waiting period for the disabled). Finally, many communities lack public housing or physician care, and where such care is available it is often so oversubscribed that new users find it essentially unavailable." *Id.* at 26.

[47]The major policy approaches to this issue are embodied in the following bills, introduced during the 1st Session of the 94th Congress: H.R. 3208, H.R. 4004, and H.R. 5000. For a discussion of these measures and their strengths and weaknesses, see Schechter, *Health Insurance for the Jobless*, Washington Post, April 6, 1975, at C-5, col. 1.

[48]See Iglehart, *Health Report/Jobless Medical Aid Debate Focuses on Financing Method*, 7 NAT. J. REP. 457 (1975); Iglehart, *Health Report/Feuding, Ford Opposition Peril Jobless Health Insurance*, 7 NAT. J. REP. 592 (1975); Iglehart, *Health Report/Speaker Supports Rogers in Dispute with Ways and Means*, 7 NAT. J. REP. 773 (1975).



and working poor. The leading proposals are all temporary in nature and would make health benefits available only to those jobless workers eligible for unemployment compensation who had health insurance coverage while employed.[49] The number of persons who would benefit from this legislation, while not insignificant, falls far short of the number of dependent upon private nonprofit hospitals for free and below-cost services.

Similarly, it is highly unlikely that a broader program of health care financing will be enacted. Many observers, including Amicus, take the position that the dependence of the poor, working poor, and medically indigent on charitable contributions for access to hospital services can only be eliminated through the enactment of a national health plan under which the entire population is entitled to comprehensive health coverage.[50] Such a scheme, it is hoped, would finance hospital and medical services for the millions who have fallen into the gap between public and private coverage, services which are now financed in part through charitable contributions. Yet the prospects for the passage of such legislation do not appear good. Given the inability of the 94th Congress to pass legislation providing health insurance coverage for the unemployed, the possibility of obtaining a consensus on a far more expensive national health insurance plan is negligi-

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[49]The only exception to this pattern is the substitute amendment for H.R. 5970, 94th Cong., 1st Sess., offered by the House Committee on Interstate and Foreign Commerce, which would extend Medicaid benefits to those receiving unemployment compensation who did not have health insurance coverage while employed.

[50]American Public Health Association Testimony in *Hearings on National Health Insurance Before the House Comm. on Ways and Means*, 93d Cong., 2d Sess., Vol. 5, at 2069 (1974).

ble.[51] And even if such a program were somehow enacted in the near future, there is no assurance whatsoever that it would obviate the need of the poor and working poor for charity care.[52]

### B. The Court of Appeals Erred in its Assumption That Government-Operated Hospital Facilities are Expanding to Provide More Services to Persons Unable to Pay.

Historically, some county and local governments have undertaken financial and managerial responsibility for the provision of inpatient and outpatient hospital services to indigents residing within their boundaries.[53] However, contrary to the assumption of the Court below, government-operated hospital care for those unable to pay is decreasing, not increasing in scope. In many areas of the country, public hospital facilities are, and always have been, nonexistent;[54] the local indigent population must continue to rely on private, nonprofit hospitals for necessary health care services on a free or below-cost basis. And in other areas of the country, county and local

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[51]This view is shared by most knowledgeable observers. See e.g., Iglehart, *Health Report/Economy taking steam from national insurance drive*, 7 NAT. J. REP. 93 (1975).

[52]See Butler & Schneider, *supra* note 36, at 3114.

[53]Between 1966 and 1974 the percentage of national health care expenditures financed through public funds increased from 25.7 percent to 39.6 percent. Worthington, *supra* note 25, at 5. During the same period the aggregate contribution to personal health care expenditures from state and local sources increased from $4,542 billion to $10,895 billion. *Id.* at 16. *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974), may cause further increases in state and local contributions toward the provision of health care services for short-term residents.

[54]H.R. REP. NO. 171, *supra* note 41, at 26.



governments have phased out their public facilities altogether or are in the process of so doing. In these jurisdictions, the dependence of the poor and working poor on private, nonprofit hospitals for free and below-cost care has demonstrably increased.

Consider, by way of example, recent developments in California, where statutory responsibility for provision of hospital and medical care to indigents lies with the counties.[55] Historically, counties had chosen to meet this obligation by establishing and maintaining hospitals, and a network of some 49 facilities evolved. In recent years, however, some financially-pressed counties have sought to eliminate the mounting deficits associated with public hospital operations by closing the hospitals altogether. Thus, as of early 1975, 8 counties had closed their hospitals, and 5 more were on the verge of taking the same action.[56] Where such closings occur, the private, nonprofit hospitals become the sole source of hospital services for the uncovered poor and working poor. When these private institutions refuse to make free or below-cost services available, those persons unable to pay or have payment made on their behalf must either forego the care or travel to a neighboring county with the hope—and nothing more—of obtaining treatment from a public or private facility there.

Where states and their political subdivisions continue to operate public hospitals, they have often failed to provide the financial support necessary to assure the maintenance of acceptable standards in the quality of

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[55]CAL. WEL. & INST'NS. CODE, §17000 (WEST 1972).

[56]E. BLAKE & T. BODENHEIMER, CLOSING THE DOORS ON THE POOR: THE DISMANTLING OF CALIFORNIA'S COUNTY HOSPITALS 61-71 (1975).

care.[57] Often, the overcrowding and deterioration of these facilities is aggravated when nonprofit, tax-exempt hospitals divert all persons unable to pay the full charge for their services to the public hospital.[58] The resulting quality deficiencies have recently been the focus of strikes by many of the physicians who staff these facilities.[59] In recognition of these shortcomings, Congress last year enacted legislation which, *inter alia*, authorizes the appropriation of funds to assist publicly-owned or operated facilities to bring themselves into compliance with applicable licensure and accreditation standards.[60] It does not appear, however, that any

[57]Mann, *Hospital Shortcomings Cited*, Washington Post, June 12, 1975, at 1, col. 1; Andelman, *City Hospital Agency Nearing Insolvency*, N.Y. Times, Jan. 5, 1975, at 1, col. 5; LARGE URBAN PUBLIC HOSPITAL AMBULATORY SERVICES PROJECT, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES, THE FINANCIAL STATUS OF THE LARGE URBAN PUBLIC HOSPITAL: THE EXPENSE, REVENUE AND BUDGET RELATIONSHIP 2-6 (1971).

[58]*Supra*, note 16.

[59]See N.Y. Times, Mar. 18, 1975, at 50, col. 4; L.A. Times, May 11, 1975, at 1, col. 5.

[60]Section 1625(a)(2) of the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 2 U.S. Code Cong. & Admin. News 2584 (1975). In explaining the purposes of this section, the Senate Committee on Labor and Public Welfare observed: "Evidence presented at hearings before the Health Subcommittee indicates that as a class, large urban hospitals are in greatest need of modernization and have the fewest sources of funds, other than Federal grants, to undertake such needed updating and upgrading of facilities. Members of the Committee have visited many urban hospitals personally, and have observed first-hand the antiquated, overcrowded, dangerous, and degrading state of many of our large hospitals. In the view of the Committee, it is the responsibility of the Federal government to intervene in this sorry state of affairs." S. REP. NO. 1285, 93d Cong., 2d Sess., 4 U.S. Code. Cong. & Admin. News 7842, 7898 (1975).



monies will actually be appropriated for such purposes in the foreseeable future.[61]

Even where public hospital facilities are capable of providing care of acceptable quality, cost-conscious county or municipal governments often impose restrictions on eligibility for such services which exclude many low-income persons who have no other hospitalization coverage. This Court recently overturned one such restriction, holding that an Arizona county could not constitutionally condition the receipt of nonemergency hospitalization and medical care upon one year's residence, *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974). And in California, several counties have established income eligibility levels that are coterminous with those of the State's Medicaid program; thus, the many families living in these counties who earn slightly more than the Medicaid income level but do not have private health insurance are excluded from the public facility.[62] The need of such persons for charity care is equally as pressing as the need of those residing in areas where public facilities are either non-existent or overcrowded.

[61]Although the minimum authorization level for such project grants for Fiscal Year 1976 is 22 percent of $130 million, or $28.6 million, the President's F.Y. 1976 Budget requested no appropriations under this authority. INSTITUTE OF MEDICINE, THE ADMINISTRATION'S 1976 BUDGET: THE HEALTH BUDGET 25 (1975).

[62]LEGISLATIVE STAFF TASK FORCE ON U.C. MEDICAL EDUCATION PROGRAMS, REPORT TO: ASSEMBLY WAYS & MEANS COMMITTEE AND SENATE FINANCE COMMITTEE, IV-4, 1975-1976 REGULAR SESS. CALIF. LEGISLATURE (1975).

### C. The Court of Appeals Erred in Assuming That Private, Nonprofit Hospitals are not in a Financial Position to Deliver Free and Below-Cost Services to Persons Unable to pay.

Underlying the Court of Appeals' decision is the assumption that an increase in the costs of capital, labor, and supplies, combined with a reduction in the amount of philanthropic contributions, has largely eroded the financial capacity of all private, nonprofit hospitals to deliver free or below-cost services. This assumption, in turn, implies that continued application of Revenue Ruling 56-185 would undermine the fiscal solvency of such valuable community resources, perhaps driving some to bankruptcy. Amicus respectfully submits that the available evidence does not support either of these assumptions and cannot justify abandonment of the federal health policy embodied in Revenue Ruling 56-185.

For obvious reasons, neither Amicus nor the class of low-income Americans represented by Plaintiffs herein has any interest in undermining the ability of needed private, nonprofit hospitals to deliver appropriate, high quality emergency and nonemergency care. Nor would reversal of the ruling of the Court below, as urged by Amicus, produce such a result. The free and below-cost service requirement contained in Revenue Ruling 56-185 expressly applies "only to the extent of [the tax-exempt hospital's] financial ability." Thus, even if it intended to do so, the Internal Revenue Service could not, consistent with this ruling, force a tax-exempt hospital to jeopardize its fiscal solvency, by providing excessive amounts of free care to indigents. Amicus has no knowledge of any private, nonprofit hospitals which were forced into



bankruptcy by providing excessive amounts of free care to indigents under Revenue Ruling 56-185.[63]

The capacity of a private, nonprofit hospital to provide free or below-cost services to indigents is measured by the bottom line—*i.e.*, the excess of revenues over expenses, often termed "net income." The greater the net income, the greater the hospital's capacity to deliver free services.[64] The size of a hospital's net income, in turn, is determined by a number of factors, including patient

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[63]While private nonprofit hospitals are by no means immune to bankruptcy, excessive volumes of charity care are not normally the source of financial difficulty. Instead, the evidence suggests that a far more significant factor in determining a private nonprofit hospital's financial condition is surplus bed capacity combined with an increasing reliance on debt as a source of capital. Decreasing occupancy levels compromise a facility's capacity to service its debt and may eventually lead to insolvency. F. SATTLER & M. BENNETT, A STATISTICAL PROFILE OF SHORT-TERM HOSPITALS IN THE UNITED STATES AS OF 1972 48 (1974).

[64]Net income, defined as the excess of revenues over expenses, understates the capacity of a private nonprofit hospital to deliver free and below-cost care to indigents. As explained by a leading authority on hospital economics, a more accurate measure of the discretionary funds available to a hospital is its cash-flow position, or net income plus depreciation expense: "Since hospitals receive a large proportion of their capital funds from government grants and donations, hospital depreciation expenses do not play the same role as depreciation funds in other types of businesses. Typically, hospital depreciation expenses are not funded or restricted to replacement of existing capital facilities, so they may be used for any of several purposes. The excess of revenues over expenses other than depreciation reflects more accurately than net income data, therefore, the pool of funds available to the hospital for future use." Davis, *Community Hospital Expenses and Revenues: Pre-Medicare Inflation*, 35 SOCIAL SECURITY BULL. 3, 14 (Oct. 1972). Future use, of course, could involve the provision of free and below-cost services.

revenues, philanthropic contributions, labor costs, capital expenses, and other operating costs.[65] Each of these factors, in turn, is a function of many other variables.[66] Generalizations regarding the financial positions of private nonprofit hospitals are therefore hazardous, at best. Nonetheless, a few observations should be made for the benefit of the Court.

First, contrary to the apparent assumption of the Court below, there is abundant evidence suggesting that many private, nonprofit hospitals have the financial capacity to provide free or below-cost services to indigents. A study undertaken by the Social Security Administration found that during the period 1961-1971, total revenue of private, nonprofit hospitals rose from $4.7 billion in 1961 to $16.8 billion in 1971, while expenses increased somewhat less, from $4.5 billion to $16.3 billion. Thus, "overall net income grew tremendously," from $91 million in 1961 to $457 million in 1971.[67] Thus, although the individual financial condi-

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[65]Pettengill, *The Financial Position of Private Community Hospitals, 1961-71*, 36 SOCIAL SECURITY BULLETIN 3, 4-11 (Nov., 1973).

[66]Patient revenues, for example, are determined by (1) utilization of the hospital's inpatient and outpatient services, (2) the proportion of patients with public or private hospital coverage, (3) the prices paid by third party payors, (4) the prices paid directly by individual patients, (5) hospital size, and (6) types of services offered.

[67]Pettengill, *supra* note 65, at 4-5. Aggregate net income for private nonprofit hospitals in 1972 was $358.1 million. HOSPITAL STATISTICS 102 (1972 ed.). The corresponding figure for 1973 was $333.2 million. HOSPITAL STATISTICS 198 (1974 ed.). This slight decline in net income of all private nonprofit hospitals during 1972 and 1973 reflects in large measure the impact of price

[footnote continued]



tions of many private, nonprofit hospitals have changed in recent decades, some for better, some for worse, Amicus submits that the improved financial position of private, nonprofit hospitals in the aggregate cannot justify the fundamental reversal in federal health policy undertaken by the Internal Revenue Service in 1969.

Elimination of the requirement that private, nonprofit hospitals provide free and below-cost services to the poor in order to qualify for charitable, tax-exempt status removed a cornerstone from the system by which hospital services for the poor are financed in this country. Currently, the costs of providing "charity care"[68] are shared by the public and private sectors. The public

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controls under the Economic Stabilization Program, *supra* note 22. Comparable data for 1974 will reflect the expiration of price controls but will not be available until August, 1975. However, in light of the 18 percent average increases in daily room rates during that period, it may reasonably be anticipated that hospital revenues will increase, producing a more favorable net income picture. Moreover, notwithstanding the decrease during 1972 and 1973, aggregate net income remained at well over $325 million each year, indicating that many private nonprofit hospitals were in a financial position to provide free and below-cost care to indigents. And again, net income is a conservative measure of the discretionary funds available to nonprofit hospitals, *supra* note 64.

[68]For purposes of assessing a hospital's capacity to deliver free and below-cost services to those unable to pay, it is essential to distinguish between "charity care" and "bad debts." The former term refers to the value of outpatient or inpatient care rendered to indigent or medically indigent patients at no charge or at a rate below normal charge. In contrast, the term "bad debts" refers to the value of outpatient care rendered to individuals other than indigents or medical indigents for which payment cannot be collected. While hospitals sometimes combine these costs for purposes of third-party reimbursement, the obligation at issue here concerns only "charity care," not "bad debts."

sector subsidizes the purchase of hospital care by large numbers of indigents, principally through Medicaid[69] and, to a lesser extent, through Medicare. A portion of the costs of providing care to indigents not covered by these public programs has traditionally been, and continues to be, borne by the paying patients of private, nonprofit hospitals.[70] The remainder is met by philanthropic contributions which, until the issuance of Revenue Ruling 69-545, were stimulated by tax incentives designed to benefit those unable to pay while at the same time lessening the burdens of government.

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[69]One state, Arizona, still does not participate in Medicaid. Thus, private nonprofit hospitals in that state do not have the benefit of Medicaid reimbursement for services rendered to persons who would be eligible were the program in operation. It is therefore understandable that appellant in *Memorial Hospital v. Maricopa County*, 415 U.S. 250, 265 (1974), found itself in "precarious financial straits." The circumstances described in that case, however, do not obtain in any other state, where the provision of care to indigents is financed in part by Medicaid.

[70]From the standpoint of the hospital, paying patients fall into two major reimbursement categories: those who pay "reasonable costs," and those who pay "charges." Medicare and Medicaid beneficiaries, as well as many Blue Cross plan subscribers, have "reasonable costs" paid on their behalf for covered services. Patients with indemnity insurance coverage, as well as those who self-insure, pay "charges"; this category is often referred to as the "self-pays." Those patients who pay "charges" must usually pay more than those paying "reasonable costs" for the same hospital services. Thus, the self-pays (and philanthropy) tend to bear that portion of the cost of providing free and below-cost services to indigents which is not covered by charitable contributions. Although this subsidy scheme raises serious questions as to the equity of burden as among different classes of patients with different sources of payment, historically this has been, and continues to be, the method for financing free and below-cost services to indigents.



Philanthropic contributions to private, nonprofit hospitals may have declined in recent years in relation to hospital operating costs, but these dollars remain critical to the ability of such facilities to render free and below-cost services.[71] Where a nonprofit hospital so chooses, it can solicit charitable contributions that are either unrestricted or specifically designated for the provision of free or below-cost services. Indeed, many private, nonprofit hospitals have done so in the past. As the Vice President of the major health-oriented private foundation recently observed.

> . . . [p]rivate philanthropy often supplies the "critical glue" required to underwrite the losses of hospitals and clinics that serve low-income and poor patients without adequate governmental or private insurance coverage. . . . Although this philanthropic support is small in dollar amount, without it many of these health institutions could not remain financially solvent.[72]

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[71]Hospitals are second only to religious institutions in their capacity to attract the philanthropic dollar, surpassing education, social welfare, and the arts and humanities. Of the $25.15 billion in philanthropy in 1974, $3.9 billion, or 15 percent, went to health and hospitals. AMERICAN ASSOCIATION OF FUND RAISING COUNSEL, GIVING U.S.A.; ANNUAL REPORT, 1975. These philanthropic dollars have a multiplier effect with respect to capital financing; they often function as "seed money" which "enables the hospital to qualify for governmental grants and to reach that level in its capital structure at which it can attract favorable long-term loans, often essential today in the financing of hospital construction." Kernaghan & Manzano, *The Complex Face of Charity*, 49 HOSPITALS 47, 50 (June 1, 1975).

[72]Blendon, *The Changing Role of Private Philanthropy in Health Affairs*, 292 NEW ENG. J. OF MEDICINE 946, 947-48 (1975).

Revenue Ruling 69-545, Amicus submits, will have a serious adverse effect on the incentive of private non-profit hospitals to continue using charitable contributions to finance the provision of free and below-cost care.

Medicare and Medicaid reimbursement policies are predicated on this dual public and private financing of care for the poor. The "reasonable cost" reimbursement formulas for inpatient hospital services under Medicare and Medicaid do not make any allowance for either "charity care" or "bad debts" attributable to those other than program beneficiaries.[73] Congressional intent, as evidenced by the Report of the Senate Finance Committee on the original Medicare and Medicaid legislation, was clearly to absorb some of the charity care burden—*i.e.*, that attributable to program beneficiaries—but to leave the remainder to the private sector:

> In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The [Medicare Hospital Insurance program] will reduce the losses of hospital income

[73]42 U.S.C. §1395x(v)(1)(A)(i) requires that the Secretary of HEW, in promulgating regulations defining "reasonable cost," must assure that "under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . ." Medicare will, however, pay for bad debts directly attributable to the inability to collect deductible and coinsurance amounts from Medicare beneficiaries. 20 C.F.R. §405.420 (1972).



> from bad debts or for care of free or part-pay aged persons which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible and coinsurance, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. . . . [t]he proposed amendments would require, under the medical assistance [Medicaid] and maternal and child health and crippled children programs of the Social Security Act, the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing income deficits arising out of providing hospital care to persons unable to pay for care.[74]

In taking this approach, the Committee built upon the traditional method of financing charity care in the private sector: through philanthropic contributions, and through charity care factors added onto the charges billed to paying patients. The legislative intent was that Medicare and Medicaid funds reduce the need for these private subsidies but not that federal subsidies replace private subsidies altogether:

> [Medicare and Medicaid] will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment sys-

[74]S. REP. NO. 404, 89th Cong., 1st Sess., 1 U.S. Code Cong. & Admin. News 1977-78 (1965).

> tems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.[75]

Congress has reconsidered the definition of "reasonable cost" and Medicare and Medicaid reimbursement policy on charity care on several occasions since the enactment of the initial legislation. However, it has never departed from the basic principle that the costs of free and below-cost care attributable to those other than Medicare or Medicaid beneficiaries were to be borne by other hospital patients and philanthropy.[76] Revenue Ruling

[75] *Id.* at 1978. The Committee's view finds empirical confirmation in the impact of Medicare and Medicaid reimbursement on the net income of private nonprofit hospitals during the first six years of these programs: "The Medicare program, for example, enabled elderly citizens to obtain hospital care and thus contributed to a significant increase in the share of total inpatient days used by persons aged 65 and over. Before the program began in 1966, many persons in that age group received hospital care as charity patients or at reduced rates. To the extent that this situation did exist, losses of hospital revenues in the form of bad debts or charity care for the aged must have been nearly eliminated once the program began. No evidence on the trend in utilization by individuals with low income is available, but the fact that public assistance vendor medical payments went from $0.1 billion to $1.6 billion during the decade suggests that Medicaid probably had the same kind of effect on hospital revenues, though perhaps not to the same degree." Pettengill, *supra* note 65, at 7-8.

[76] Congress considered and amended the "reasonable cost" formulas under Medicare and Medicaid in passing the Social Security Amendments of 1972, Pub. L. No. 92-603, but left undisturbed the prohibition against reimbursement of participating providers for the costs of charity care rendered to those indigents not eligible for Medicaid or Medicare. Since the enactment of Medicare and Medicaid, this clear Congressional insistence on

[footnote continued]



69-545 is, of course, wholly inconsistent with this legislative scheme, since it eliminates the tax incentives for these private subsidies.

Finally, creation of incentives for allocating philanthropic resources toward the provision of free and below cost services, as would occur under Revenue Ruling 56-185, has much to recommend it from the standpoint of national health policy. To the extent that charitable contributions are unrestricted, hospitals are most likely to apply them either toward offsetting charity care losses or financing modernization or expansion.[77] A compelling

private participation in the financing of hospital care to indigents has been a major point of contention with the American Hospital Association: "The passage of Public Law 89-97 underscored the fundamental weaknesses in health care financing. This governmental program assumed the burden for the payment of health care bills of a large segment of the population but explicitly renounced any obligation to share in the meeting of the total needs of our health care system, except as that system met the needs of the program beneficiaries. All contracting agencies, jointly and separately, must recognize the total community services obligations of the providers of service." AMERICAN HOSPITAL ASSOCIATION, STATEMENT ON THE FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES iii (1969). Congressional commitment to the obligation of private nonprofit hospitals for the provision and, through their patients and charitable contributions, the financing of free and below-cost services to indigents was recently reaffirmed through the enactment of §1604(b)(1)(J)(ii) of the National Health Planning and Resources Development Act of 1974, *supra* note 60, which sets forth the obligation of recipients of construction and/or modernization funds to make a "reasonable volume" of services available to those unable to pay therefor.

[77] Revenue Ruling 69-545 offers the following example: "Hospital A is a 250-bed community hospital. . . . Patients who cannot meet the financial requirements for admission are ordinarily

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case can be made that much of the hospital construction now proposed is not in the public interest. In 1974, conservative estimates placed the number of excess, unnecessary acute care hospital beds in America at between 67,000 and 110,000.[78] Since the maintenance costs for each empty hospital bed average $20,000 per year, the cost to society of this excess hospital capacity amounted to approximately $2 billion that year.[79] In recognition of this waste, Congress recently enacted legislation providing for tighter controls on hospital expansion.[80] Thus, to the extent that Revenue Ruling

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referred to another hospital in the community which does serve indigent patients. The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research."

[78]In 1972 the federal Hill-Burton agency estimated that there were 110,000 excess acute care hospital beds in the United States. U.S. DHEW HEALTH RESOURCES ADMINISTRATION, HEALTH CARE FACILITIES SERVICES, GENERAL HOSPITALS AND OUTPATIENT FACILITIES, EXISTING AND NEEDED AS OF JAN. 1, 1971 (1972). The 67,000 estimate of excess beds is based on a private study assuming that an optimal nation-wide occupancy rate is 81 percent. See SATTLER & BENNETT, *supra* note 63.

[79]REGIONAL HEALTH PLANNING COUNCIL, NORTH CENTRAL TEXAS COUNCIL OF GOVERNMENT, THE FINANCIAL IMPACT OF HOSPITAL OVERBEDDING (June 1974).

[80]Section 1623(a)(4)(B) of the National Health Planning and Resources Development Act of 1974, *supra* note 60, conditions the receipt of resources development funds by a State upon its establishment and administration of a certificate of need program which will "provide that only those services, facilities, and organizations found to be needed shall be offered or developed in

[footnote continued]



69-545 diverts philanthropic funds from charity care to hospital expansion, it is arguably doing the nation a serious and costly disservice.

## III.

## REVENUE RULING 69-545 DOES NOT SET FORTH A SATISFACTORY MEANS BY WHICH HOSPITALS CAN MEET THEIR LEGAL OBLIGATION TO PERSONS UNABLE TO PAY.

### A. Medicaid and Medicare Patients are not Persons Unable to Pay.

In requiring hospitals to accept beneficiaries of the Medicaid and Medicare programs, Revenue Ruling 69-545 does not thereby provide for persons unable to pay for hospital care. Medicare and Medicaid pay hospitals the full amount of costs actually incurred in connection with the provision of services to program beneficiaries.[81]

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the State." The intent of this requirement is, *inter alia*, to control expansion of bed capacity by private nonprofit hospitals. S. REP. NO. 1285, 93d Cong., 2d Sess., 4 U.S. Code Cong. & Admin. News 7878-79 (1974).

[81]See *Catholic Medical Center v. Rockefeller*, 305 F. Supp. 1256 (E.D. N.Y. 1969), vacated and remanded, 397 U.S. 820 (1970), order reentered, 305 F. Supp. 1268 (E.D. N.Y. 1970), aff'd *per curiam*, 430 F.2d 1297 (2d Cir. 1970), appeal dismissed, 400 U.S. 931 (1970).

See also 39 FED. REG. 31766 (1974), in which the Secretary of HEW notes that the federal Medicaid law requires full payment of all reasonable costs and states: "Concern has been expressed by representatives of the American Hospital Association that some States have in the past, in violation of their Title XIX State plans, failed to reimburse hospitals at the required reasonable cost level . . . The Secretary knows of no instance, however, in which such a violation has occurred without being promptly rectified with full reasonable cost reimbursement of all services

[footnote continued]

Rather than undermining the financial position of private, nonprofit hospitals, "reasonable cost" reimbursement under Medicare and Medicaid have greatly improved the economic position of these institutions.

Hence, this requirement is nothing more than a statement that exempt hospitals may not arbitrarily discriminate against certain classes of people who are able to pay the full cost of the service. Sound policy reasons support a rule that tax-exempt hospitals should not arbitrarily discriminate against particular groups of people who are fully able to pay, whether that discrimination is based on race, age or economic class. However, prohibiting arbitrary discrimination against particular classes of patients does not meet the statutory requirement that nonprofit hospitals must provide charity in order to be tax-exempt.

**B. Emergency Room Care is Not a Satisfactory Means of Meeting the Needs of Persons Who Require Free and Below-Cost Hospital Care.**

The requirement that a private, nonprofit hospital have an emergency room does not in itself fulfill the legal obligation to provide free services to persons unable to pay. Far more crucial to persons unable to pay is the extraordinary expense of inpatient hospital care, which is not available in the emergency room.

Furthermore, the meaning to be given to "emergency room service" is itself vague and ambiguous. The Court of Appeals, 506 F.2d 1278, 1289 seems to be referring to

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provided by hospitals. If there should in the future be any instance in which States fail to adhere to State plan requirements, affected hospitals are urged to so inform the appropriate Regional Commissioner of the Social and Rehabilitation Service."



the practice of providing outpatient services to poor persons in the emergency room when they do not have access to a private physician. The unmistakable trend, however, is for hospitals and other community facilities to set up clinics outside the emergency room to provide non-emergency outpatient care.[82] The legislative history of the Emergency Medical Services Systems Act, [42 U.S.C. §300d, *et seq.*] in acknowledging the extensive use of the emergency room for non-emergency outpatient services, contains the observation that,

> This increased community reliance on the services of the emergency room has overburdened its resources and has vastly compounded the difficulties of providing effective critical care to the emergency victim.[83]

Emergency room care is defined to mean only that care which a hospital chooses to provide in its emergency room.[84] Thus, it would appear that a hospital which improves the capacity of its emergency room to handle true emergencies thereby divests itself of any further obligation to provide outpatient services for persons unable to pay.

Nor is it necessarily advisable to require a hospital to operate an emergency room. Over 37% of the private nonprofit hospitals in this country do not have "basic

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[82]Jacobs, Gavett, and Wersinger, *Emergency Department Utilization in an Urban Community*, 216 AM. MEDICAL ASSN. J. 307 (1971); AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES 53-54 (1972).

[83]S. REP. NO. 397, 93d Cong., 1st Sess., 2 U.S. Code Cong. & Admin. News 2548 (1973).

[84]AMERICAN HOSPITAL ASSOCIATION, EMERGENCY SERVICES viii (1972).

emergency services."[85] Federal policy has sought to coordinate emergency services in a particular area, and the Emergency Medical Services Systems Act (42 U.S.C. §300d) seeks effective utilization of available, personnel, facilities and equipment, [42 U.S.C. §300d-5(b)(4)(C)(vii)] while "avoiding expensive and unnecessary duplication of equipment and facilities and poor utilization of scarce staff and financial resources."

If "emergency room care" is intended to refer to the primary function of emergency rooms in providing acute emergency care arising out of trauma, accidents, and other serious, unpredicted events,[86] this function is considered a cost of doing business for any hospital, including for-profit concerns, and is not classified as charity care.[87] On the contrary, the hospital is free to

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[85]J. OF THE AM. HOSPITAL ASSN., Guide Issue, 484 (Aug. 1971).

[86]Torrens and Yedvab, *Variations Among Emergency Room Populations: A Comparison of Four Hospitals in New York City*, 8 MEDICAL CARE 60 (1970).

[87]Hospitals provide emergency services more to protect themselves from a lawsuit than to protect their tax-exempt status. Developing state court case law is following *Manlove v. Wilmington General Hospital*, 54 Del. 15 (1961) 174 A.2d 135 (1961) which held that a hospital operating an emergency room is holding itself out to the public as providing emergency services and therefore cannot refuse service to anyone. In some states, all hospitals have a statutory duty to render emergency services if they operate an emergency room. See ILLINOIS CODE, Chapt. 111 1/2, No. 86; CALIFORNIA HEALTH AND SAFETY CODE §1317. In order to qualify for funds under The Emergency Medical Services System Act (1973), 42 U.S.C. §300d *et seq.*, a hospital or service area would have to, "provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services . . ." 42 U.S.C. §300d-5(b)(4)(C)(ix).



transfer the patient to another hospital after only the most cursory form of first-aid is provided.

## IV.

### THE FAR-REACHING CHANGES IN THE "CHARITABLE" STATUS OF PRIVATE, NONPROFIT HOSPITALS COULD BE EFFECTUATED, IF AT ALL, ONLY AFTER COMPLIANCE WITH THE ADMINISTRATIVE PROCEDURE ACT.

The American Public Health Association believes that Revenue Ruling 69-545 represents a drastic change in the previous law, eliminates important rights of the citizens whom Petitioners represent, has a substantial impact upon both the public and private sectors of the hospital industry, and is necessarily predicated upon assumptions of fact which are not within the particular expertise of the Respondent. Under settled principles, all of these reasons require that the Respondent comply with the rule making procedurees of the Administrative Procedure Act.[88] If the Respondent had complied with the procedures mandated by the Administrative Procedure Act, and had received a full range of relevant information, we believe that the policy change effectuated by Ruling 69-545 might never have been made.

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[88]See *Lewis-Mota v. Secretary of Labor*, 469 F.2d 478 (2d Cir. 1972); *Texaco v. Federal Power Comm'n*, 412 F.2d 740 (3d Cir. 1969). See also, *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971).

## CONCLUSION

For the reasons set forth, this Court should reverse the judgment of the Court of Appeals and grant to plaintiffs such other and further relief as this Court deems proper.

Respectfully submitted,

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